



JUVENILE REHABILITATION ADMINISTRATION (JRA)
JRA MINIMUM SECURITY FACILITY

CONDITIONS OF TREATMENT PROVIDER AGREEMENT

RESIDENT'S NAME	NAME OF BUSINESS
MINIMUM SECURITY FACILITY COUNSELOR'S NAME	NAME OF IMMEDIATE SUPERVISOR(S)
MINIMUM SECURITY FACILITY TELEPHONE NUMBERS	SUPERVISOR'S WORK TELEPHONE NUMBER

The resident named above is a juvenile offender who has been committed to the State of Washington for a period of incarceration. Currently, the juvenile is a resident of _____
MINIMUM SECURITY FACILITY NAME

located at _____
MINIMUM SECURITY FACILITY ADDRESS

This is a minimum security facility under the supervision of the Department of Social and Health Services Juvenile Rehabilitation Administration

(DSHS JRA). His/her current offense is _____

and he/she has a criminal record that includes _____

To be granted permission to participate in treatment, the resident has agreed to follow the conditions listed below. Staff members of
MINIMUM SECURITY FACILITY NAME will make periodic and random accountability checks while the resident is
at treatment. A monitoring check will be brief and unobtrusive, and will provide an opportunity to talk with Minimum Security Facility staff about
the resident's treatment performance. A _____ counselor monitoring the resident will contact
MINIMUM SECURITY FACILITY NAME the immediate supervisor's on a regular basis to discuss treatment performance. All _____
MINIMUM SECURITY FACILITY NAME staff will present identification when meeting with the resident or treatment provider.

If the resident violates any of the conditions listed below the supervisor is requested to immediately contact the Minimum Security Facility staff at the numbers listed above. If Minimum Security Facility staff cannot be contacted or there are other concerns that cannot be handled by the Minimum Security Facility, please contact the JRA 24 hour Hotline at 1-800-933-9122.

CONDITIONS OF TREATMENT INVOLVEMENT

1. The resident cannot leave the treatment site without prior approval of the Minimum Security Facility supervising staff.
2. The resident cannot make or receive personal telephone calls except to or from the staff of the Minimum Security Facility.
3. The resident may take rest breaks during treatment hours only in those areas at the treatment site designated for such breaks.
4. The resident cannot receive visits during treatment hours from anyone unless previously approved by the Minimum Security Facility supervising staff.
5. The resident must arrive at and leave the treatment site at scheduled times unless excused by the Minimum Security Facility staff in collaboration with the treatment provider/supervisor.

TREATMENT PROVIDER AGREEMENT

I understand the conditions of treatment listed above and that Minimum Security Facility staff will make periodic checks on this resident. I will contact the Minimum Security Facility staff immediately when I become aware that:

1. This resident is absent, tardy, or leaves the treatment site at any time without approval from the Minimum Security Facility supervising staff.
2. The resident gives notice that s/he will not report to the treatment site.
3. The resident violates any of the conditions listed above, or demonstrates other problematic behavior.

RESIDENT'S SIGNATURE	DATE	SUPERVISOR'S SIGNATURE	DATE
ASSISTANT SECRETARY/DESIGNEE SIGNATURE	DATE	MINIMUM SECURITY FACILITY CEO/DESIGNEE'S SIGNATURE	DATE

Please provide the names and work telephone numbers of any additional personnel who will supervise the resident on the treatment site.